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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

In Re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)	MDL No. 1456 CIVIL ACTION NO. 01-CV-12257-PBS
THIS DOCUMENT RELATES TO ALL ACTIONS	)	

39(b)(6) DEPOSITION OF JOHN HOFFMAN
New York, New York
Friday, March 26, 2004
9:30 a.m.

30(b)(6) deposition of JOHN HOFFMAN, held at the offices of Patterson, Belknap, Webb & Tyler LLP, 1133 Avenue of the Americas, New York, New York, pursuant to Notice, before Frank J. Bas, a Registered Professional Reporter and Notary Public of the State of New York.

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I N D E X

E X H I B I T S

E X H I B I T S (Cont'd.):

E X H I B I T S (Cont'd.):

(time noted: 9:43 a.m.)

J O H N H O F F M A N,

stating his business address as Centocor, Inc., 800 Ridgeview Drive, Horsham, Pennsylvania 19044, having been duly sworn by the Notary Public (Frank J. Bas), was examined and testified as follows:

EXAMINATION BY

MR. MACORETTA:

Q. Mr. Hoffman, good morning.

A. Good morning.

Q. My name is John Macoretta, I'm here on behalf of the plaintiffs in this litigation. First of all, have you ever given a deposition before?

A. No.

Q. Okay. Let me just talk to you a little bit about the procedure before we get started.

MR. HAAS: John, just before we get too far into it, I'll just make a statement for the record.

MR. MACORETTA: Sure.

MR. HAAS: Mr. Hoffman is here pursuant to an amended notice of Rule 30(b)(6) Deposition dated December 3, 2003.

The areas of inquiry specified in Exhibit A of the Amended Notice of Rule 30(b)(6) Depositions calls for testimony of a highly confidential nature, and Centocor therefore designates the transcript in this matter Highly Confidential-Attorneys' Eyes Only, under the protective order entered into this case.

MR. MACORETTA: Okay.

BY MR. MACORETTA:

Q. Mr. Hoffman, as undoubtedly your counsel has explained, I'll ask you some questions, you'll answer them today. While I can see you nod your head, the court reporter can't take that down, so you have to say yes or no or whatever you're going to say. Okay?

A. Yes, sir.

rest.

Q. By the way, the spreads on this chart actually range from 19 percent to 73.8 percent, don't they?

MR. HAAS: Objection to form.

Q. You could answer that.

A. Yes. But the majority of them are between 20 and 30.

Q. I'm looking now to the next page, 147, which is Average Wholesale Price Goals. The first one says set AWP consistent with end user pricing sensitivity. What does end user mean there?

MR. HAAS: Objection to form, foundation. You can answer.

A. My guess there would be patients, in terms of what they could afford from a co-pay standpoint.

Q. And the next bullet point, "Set AWP to provide adequate margin for infusers."

What does adequate margin mean? What does adequate margin mean on that page?

MR. HAAS: Objection to form, foundation.

A. Consistent with what I think we've tried to reflect throughout the rest of the document, it is to provide enough difference between the acquisition price and the reimbursement to appropriately reimburse the physicians for the costs and risks associated with the therapy.

Q. By the way, this says set AWP, doesn't it? As opposed to recommend AWP?

MR. HAAS: Objection, the document speaks for itself.

Q. Can you point --

MR. MACORETTA: Strike that.

Q. Can you point to anywhere in this document where it references recommending or encouraging an AWP as opposed to actually setting the AWP? Take as much time as you want to look at it.

(Witness reviews document.)

MR. HAAS: Note my objection to form.

(Witness reviews documents.)

A. No, I can't.

Q. Okay. As part of its efforts to ensure that Remicade users were comfortable infusing Remicade in the office, Centocor developed something called the practice management program?

MR. HAAS: Objection to form.

MR. MACORETTA: Strike that.

Q. Did Centocor at one point develop something called the practice management program?

A. Yes.

Q. Are you familiar with that?

A. Yes.

Q. Can you explain to me what that is?

A. Yes.

Q. Please do.

A. As I mentioned before, our market research and knowledge of the physicians that we were going to be launching the product to, and knowledge of the payer world that we were going to be entering into, indicated that there were

significant complexities associated with not only setting up initially in-office infusion in a physician office, but on an ongoing basis making sure that the billing, coding, reimbursement, scheduling, handling of infusion reactions, all of the things associated with setting up for -- setting up for delivering, and then getting reimbursed for an infusion, so we established these programs to provide education and tools to physicians to help them not only get over some of those disincentives and obstacles that they had, but also to be able to deliver those infusions in a more effective and efficient manner on an ongoing basis.

Q. Is it fair to say that one goal of the practice management program was to convince physicians that there was an economic incentive to prescribe Remicade? Or infuse it in their office, I should say?

A. No, I wouldn't characterize it that way. I would represent that the economic feasibility associated with the decision to

deliver in-office infusions needed to be assessed, and that's what the purpose of these programs and tools were, was being able to assess that economic impact and determine whether it was going to be a profit or a loss, and then move forward with a decision on an individual physician basis, based on their particular situation.

Q. But certainly part of the goal of the program is to demonstrate how it was possible that in-office infusion could be a profit to the physicians?

MR. HAAS: Objection.

A. As I mentioned, the goal was not to show that it could be profitable. The goal was to overcome the disincentives that we were told by physicians existed as an obstacle to deciding to begin infusing in-office.

Q. And one of those disincentives was that the cost of providing in-office infusion outweighed the benefit of it, right?

A. Potentially.

Q. Okay. So if overcoming the disincentive of the cost outweighing the benefit -- strike that.

Doesn't overcoming the disincentive of the cost outweighing the benefit mean showing how the benefit outweighs the cost?

MR. HAAS: Objection to form.

A. I'm sorry, can you restate the question that's out there?

MR. MACORETTA: You know what, strike that. That's fine. We'll try something else.

Q. What would you say the drug that principally competed with Remicade was? From 1998 through the present? Drug or drugs.

A. There are multiple drugs. Methotrexate, and various other DMARDS, are considered first line therapy, and many payers and physicians require that they be used first. And then when the decision is made to use a biologic, the primary competitor has been Enbrel.

Q. And Enbrel is self administered by

the patient, right?

A. In most cases.

Q. So one important distinction between Remicade and Enbrel is that Enbrel in most cases is administered by the patient, Remicade requires an infusion in an infusion setting?

MR. HAAS: Objection to form.

Q. Is that a fair statement?

MR. HAAS: Objection to form.

A. It's one of the differences, yes.

Q. I understand that. I show you what we're going to mark as Exhibit Centocor 010?

(Exhibit Centocor 010, for identification, document Bates-numbered MDL-CEN00003478 through 3499, Office-Based Infusion Guide.)

MR. MACORETTA: Off the record.

(Recess.)

BY MR. MACORETTA:

Q. Let's go back on the record. Mr. Hoffman, we've just marked as Centocor

MR. HAAS: I'll just clarify for the record that he was flipping through the pages. If you want him to go through the entire document to respond to your question, he could take that time.

MR. MACORETTA: No, that's fine.

Q. Is there any effort to quantify, in dollar terms, anywhere in here the costs of providing in-office infusion?

MR. HAAS: The same objection.

Q. You can answer.

A. No. And I asked that question, and the thought process behind that was that because salaries of nurses, et cetera, cost of space varied so much geographically, et cetera, it was too difficult to put a specific amount in there. Instead the worksheet on page 5 provides the considerations that needed to be taken into account when looking at all of the other things that might contribute to those costs.

Q. But no actual attempt to quantify those costs was made because it was determined to

be too complicated?

A. Yes. And too variable.

Q. Does it say that anywhere in here; that all of these costs are too complicated and variable to put a dollar figure on?

A. No, we didn't think it would be a good idea to give physicians something that said it was too complicated for them to understand.

Q. So you gave them a document that showed how much revenue they could bring in, but it didn't show them how much their costs would be, right?

MR. HAAS: Objection, argumentative.

Q. You can answer that.

A. We didn't try to assume what their costs were for them.

Q. Okay.

A. We tried to give them a list of all the considerations they need to take into account in making that decision for themselves.

Q. And the purpose of this was to help them analyze the financial implications of doing

in-office infusion, right?

A. That was part of it. As well as to help figure out how to do coding, et cetera.

Q. Of course, at the end of the day, Centocor's overall purpose was to get as many physicians as possible to do in-office infusions, wasn't it?

MR. HAAS: Objection to form.

A. Centocor's goal was to support in-office infusion, because we strongly believed then, and we strongly believe now, that in-office infusion is the most appropriate site of care for delivering Remicade therapy. It is the best place for the patient, because they have the highest level of comfort, and they have the consistency of being treated by their own physician, and his or her staff. It is the best place for the physician, because he or she maintains control and constant monitoring of the patient. And it's also the best for the payer, because historically the costs associated with in-office infusion are significantly lower than

the costs associated with hospital outpatient departments.

Q. Of course, none of those points you just mentioned were discussed at all in the -- in this Office-Based Infusion Guide, right?

A. I don't believe that they're relevant to the -- to the financial impact assessment, from a physician perspective.

Q. You would agree with me that a doctor would only do in-office infusion if it was going to be profitable for him, wouldn't you?

MR. HAAS: Objection to form.

A. I don't think you can make that blanket statement. I am aware of anecdotal stories of physicians who do infusions and lose money on those infusions.

Q. Was Centocor's marketing strategy based on the assumption that physicians would perform in-office infusions even though they were going to lose money on them?

MR. HAAS: Objection to form.

A. No, I don't think anyone would

introduce or develop a marketing plan and introduce a product or service to people who were going to do it in a situation where they were going to lose money.

Q. No, in fact, it would be much better if you could introduce a product or service in a situation where if someone could use it and actually make money, wouldn't it?

MR. HAAS: Objection to form.

A. As I said earlier, the decision to add any additional billable service to a practice, whether that's lab testing, whether it's x-rays, et cetera, you know, is being made from numerous considerations, but in many cases the primary one being the ability to increase billable revenue.

Q. Okay.

A. By the way, I'm just flipping back, if you look at page 4, we do say in here about the provision of high-quality care and patient convenience, and supervision of the patient, et cetera.

Q. But other than saying it here, the rest of this book talks about how much money it's going to cost, or how much money you can make; there's no other discussion in here about high-quality care, patient convenience, supervision or autonomy, is there?

A. The purpose of this particular guide was, if you look at how we trained our sales people to address this, is they first and foremost and always sold the clinical benefits of in-office infusion first.

If when some physicians were sold on that but then they raised issues about the costs and risks associated, and uncertainty associated with investing in that capability, we wanted to have this tool available to help address those risks, and allow them to provide the therapy to their patients.

Q. The financial impact worksheet on page 8, was that also available at Centocor's Web site at some point?

A. Yes, I believe it was.

Q. Were you involved at all in the decision to make that available in Centocor's Web site?

A. No, I wasn't.

Q. That's not currently on Centocor's Web site, is it?

A. No, it's not.

Q. Were you involved in the decision to take it off Centocor's Web site?

A. No, I was not.

Q. Do you know who made that decision to take it off Centocor's Web site?

A. I believe our senior management made that decision.

Q. Do you know what the reasoning for that decision was?

A. Yes.

Q. What was that reason?

A. In, I believe it was 2002, given the increased scrutiny over certain things in the entire pharmaceutical industry, Johnson & Johnson and Centocor decided to take a very cautious